COLLEGE OF PHARMACY

XAVIER UNIVERSITY of LOUISIANA

Podium Session B

Health Services, Policy and Social Determinants of Health

10th Anniversary

HEALTH DISPARITIES CONFERENCE

March 16–17, 2017 | New Orleans, Louisiana

COLLEGE OF PHARMACY

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JOIN OUR SOCIAL MEDIA DISCUSSIONS

#XUDisparitiesCollabs

10th Anniversary

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PODIUM PRESENTER

Gail D. Brekke, MAAEL,RL

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HEALTH DISPARITIES CONFERENCE

March 16–17, 2017 | New Orleans, Louisiana

Who is My Neighbor? Expansion of CERT to the University Campus and Beyond

Dennis E. Daniels, MPH;Dr.PH

Professor and Director

Gail Brekke, M.A. -Instructor

Texas Undergraduate Medical Academy

Prairie View A&M University

What IS CERT?

- CERT is the acronym for Certified Emergency Response Team.
- It was launched following the events of September 11, 2001 as a grassroots strategy to strengthen community safety and preparedness through civic engagement.
- CERT basic training is provided in 9 units including: Disaster Preparedness, Fire Safety, Medical Operations and Disaster Psychology.

Why CERT ?

- 133 million Americans – 45% of the population – have at least one chronic disease.
- Chronic diseases are responsible for seven out of every 10 deaths in the U.S., killing more than 1.7 million Americans every year.
- Chronic diseases can be disabling and reduce a person's quality of life, especially if left undiagnosed or untreated. For example, every 30 seconds a lower limb is amputated

Benefits to The University Campus and Beyond

- Individuals will be trained in Medical Operations including CPR/AED. A prepared team of persons capable of responding to heart attacks and diabetic comas will be on hand until the arrival of first responders.

- CERT members will be available for training in advanced first aid capable of addressing victims in shock or in seizure episodes.

- CERT provides exposure to health disparities for the pre-health professional student along with a prepared response that is beneficial to the University Campus and the Community at large.

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PODIUM PRESENTER

Maylott Mulugeta

10th Anniversary

HEALTH DISPARITIES CONFERENCE

March 16–17, 2017 | New Orleans, Louisiana

MOMS
(Making Our Mothers Successful)

Friday March 17th 2017

Maylott Mulugeta, BSPH—United Way of Greater Atlanta

ACKNOWLEDGEMENTS

- Kim Addie

Senior Director of Health |United Way of Greater Atlanta

- Carolina Casares

Director od Health |United Way of Greater Atlanta

- Twanna Nelson

Home Visiting Program Manager |Georgia Department of Public Health

LEARNING OBJECTIVES

1) To understand the MOMS/PAT integrated home visitation model and how it has been utilized in Clayton County, GA to support low birth weight reduction among low-income African-American women

2) To analyze the impact of effective and strong community partnerships in tackling complex social determinants of health for a target population

LIVE UNITED
United Way
United Way of Greater Atlanta

OVERVIEW

- ❑ Issue
- ❑ Program model, partners, and goals
- ❑ Key components
- ❑ Results
- ❑ Participant stories
- ❑ Challenges
- ❑ Conclusions
- ❑ Q&A

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United Way
United Way of Greater Atlanta

THE ISSUE

- Low-birth weight and premature births are the major cause of infant death in Georgia. Low birthweight rates are 9.3% compared to the national average 8%

- Clayton County has one of the state's highest infant mortality rates and a high number of infant deaths (11.8%)

- Clayton County's feto-infant mortality rate (deaths from 20-weeks' gestation through the first year of life) is **22 deaths out of every 1,000 births**. Georgia's feto-infant mortality rate is **17 deaths out of every 1,000 births**.

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United Way of Greater Atlanta

OUR SOLUTION:
MOMS (MAKING OUR MOTHERS SUCCESSFUL)

The aim of MOMS is to improve the birth outcomes of women, ages 24-44, who are most at high-risk of giving birth prematurely by making perinatal health and safety resources available to mothers from the comfort of their homes.

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OUR ROLE & PARTNERS

- United Way of Greater Atlanta (UWGA) invests, collaborates and assists with coordinating an integrated and seamless system of care for mothers and their families
- UWGA is the lead partner for this initiative, maintaining partner relationships, reviewing data and goal progress, and setting key milestones
- Our partners include: Clayton County Board of Health, Clayton Collaborative Authority, Clayton County Perinatal Coalition, and Clayton County Board of Commissioners

the Clayton COLLABORATIVE
Your Local Georgia Family Connection Collaborative

CCBoH Clayton County Board Of Health

LIVE UNITED United Way United Way of Greater Atlanta

THE GOAL OF MOMS

- Babies are born at a healthy weight ≥5.5 lbs.
- Full term births ≥37 weeks gestation
- Achieve developmental milestones (ASQ3 &SE)
- Reestablish internal infrastructure and external community capacity to support Maternal and Child Health

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KEY PROGRAM COMPONENTS

- The program employs trained home visitors to guide women through the nuances of early motherhood. Using the Resource Mothers® and Parents as Teachers® (PAT) Born to Learn© evidence-based curricula proven to improve outcomes for mothers and their children, MOMS home visitors establish bonds with young families, assess their living environment, and teach young mothers valuable parenting skills

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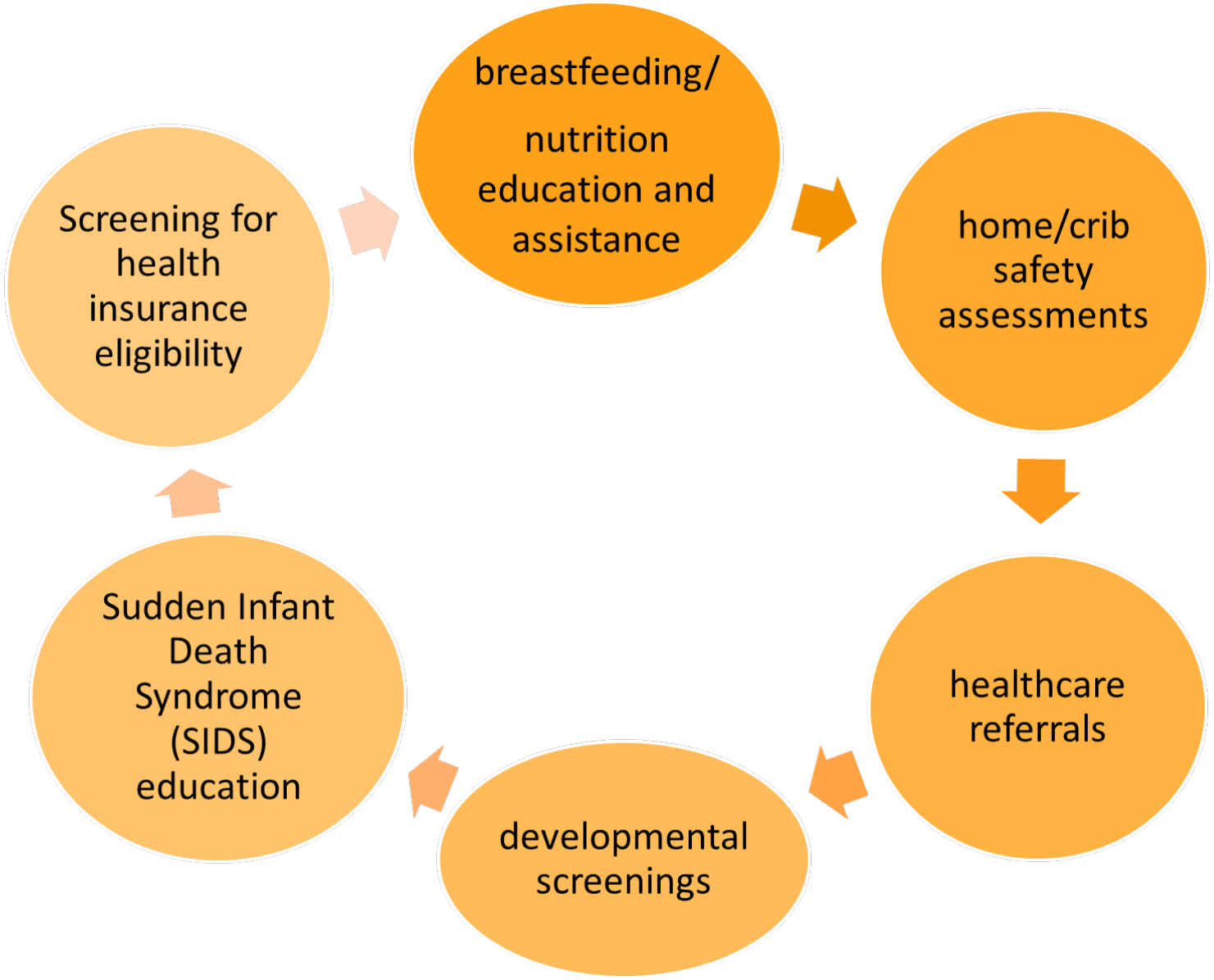
KEY PROGRAM COMPONENTS



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MEETING COMMUNITY NEEDS

In addition to receiving critical perinatal health education and social services in the home, soon to be mothers also are provided ***housing stabilization*** and ***behavioral health services*** as a part of the MOMS program

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OUR RESULTS (2015)

117

Active Participants
(58 mothers, 59 infants)

95%

Health Weight Births
(>5.5lbs)

98%

Achieved Developmental Milestones (ASQ3 & SE)

- **6.3 lbs.** average birth weight
- **84%** full term births ≥37 weeks
- **100%** families assessed for health insurance
- **410** home visits conducted
- **55** family support referrals

*In 2016, **100%** of babies from the MOMS program were born at a healthy weight ≥5.5 lbs. [56 mother & 26 babies]

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Participant Stories

"My husband lost his job. We were facing eviction. The MOMS program helped me with car seats, diapers, and everything my baby and new baby would need."

–Participant 1

"I am in the process of getting housed currently. This program helped me a lot with counseling. I had someone to talk to about my situation and find a way to cope."

–Participant 2

"I just could not afford anything. Everything is a trickle effect. This [program] was our new beginning. My kids and I can work on stability now. My babies are sleeping in their own bed, in their own room now… When I am messed up, my kids get the worst of me. I don't have as much to be mad, anger, or bitter about. I can take that energy and positively love on my kids now. Before I felt like the worst parent, they deserve better and I couldn't give it to them more…I have no idea how I am here. This program showed me it's going to get better. I thoughts about giving up my kids in order to get myself together before this program. I am so glad I did not. It just makes it all worth it."

–Participant 3

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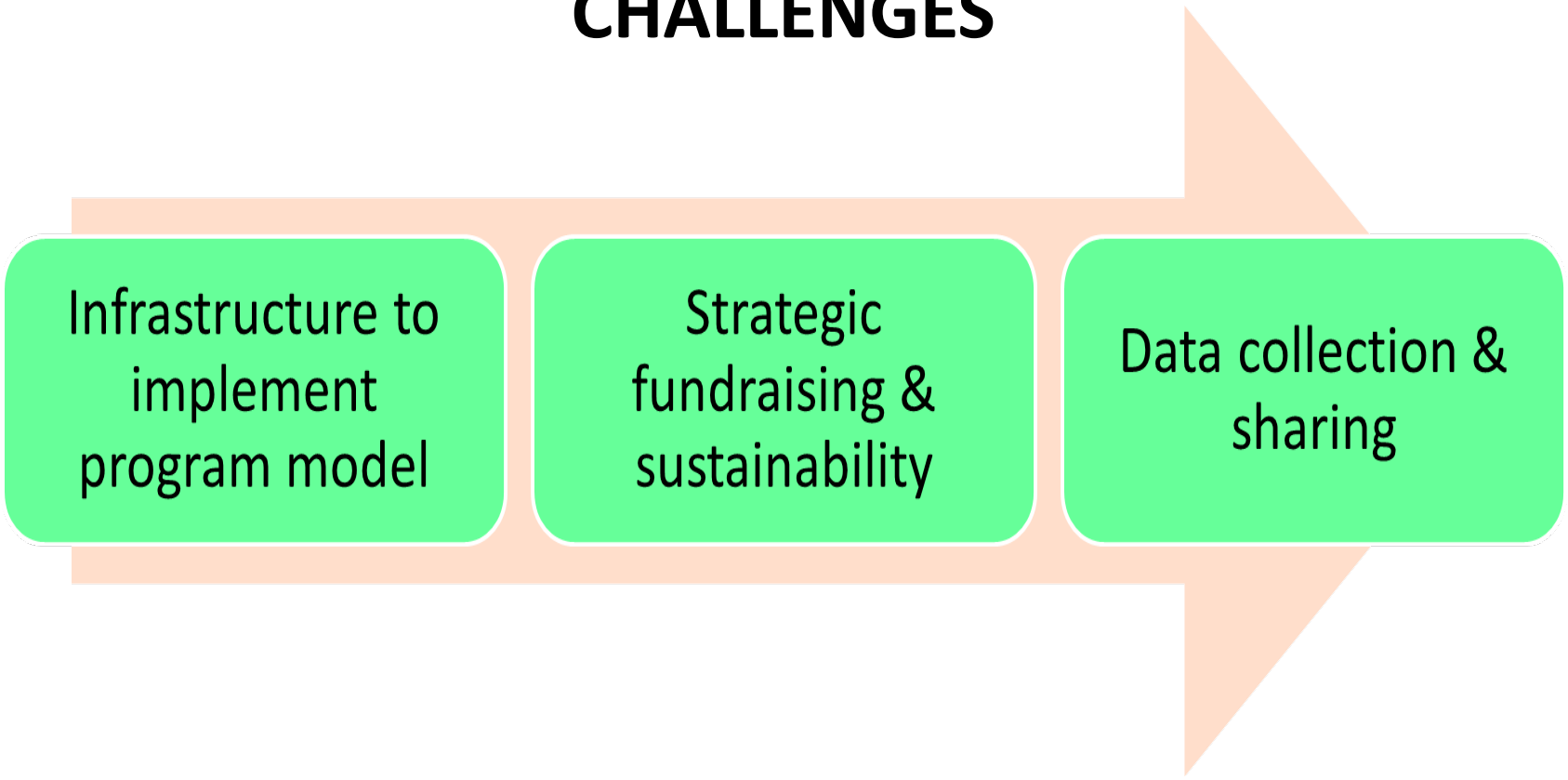
CHALLENGES



MOMS hopes to expand and scale up to other GA counties. Fundraising is currently taking place as well as advocacy efforts and donor engagement opportunities for program promotion and awareness

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CONCLUSIONS

The MOMS program creates an innovative model of care that results in improved birth outcomes for low-income, African-American women.

Outcome Measures:

- Reduction in low birthweight births among target population
- Effective perinatal health education and social services in the home
- Number of participants connected to health and/or dental care & health insurance screenings

The program also found ***housing stabilization*** and ***behavioral health services*** critical to the overall effectiveness of program model for participants

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United Way of Greater Atlanta

Questions?

For more information on the MOMS Program

Maylott Mulugeta, Health Project Coordinator—United Way of Greater Atlanta
e: mmulugeta@unitedwayatlanta.org |p: 404.527.7488

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THANK YOU

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PODIUM PRESENTER

Roslyn Holliday Moore, MS

10th Anniversary

HEALTH DISPARITIES CONFERENCE

March 16–17, 2017 | New Orleans, Louisiana

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

360 Degrees of Health Equity in Underserved Communities: A Federal Perspective Focused on Policy, Data and Practice

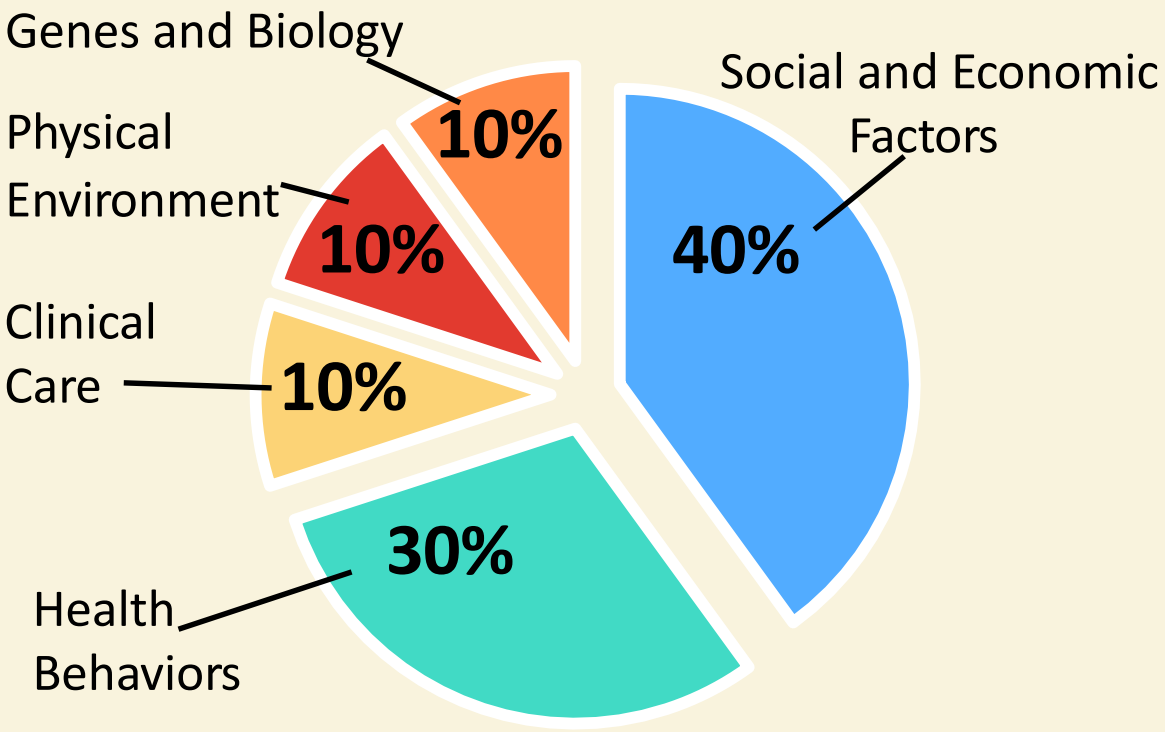
Roslyn Holliday Moore, Senior Public Health Analyst
SAMHSA, Office of Behavioral Health Equity

Xavier University of Louisiana College of Pharmacy
10th Anniversary Health Disparities Conference
New Orleans, LA
March 17, 2017

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

What Creates Health?

Determinants of Health



Determinants of Health Model based on frameworks developed by: Tarlov AR. *Ann N Y Acad Sci* 1999; 896: 281-93; and Kindig D, Asada Y, Booske B. *JAMA* 2008; 299(17): 2081-2083.

World Health Organization. Ottawa charter for health promotion. International Conference on Health Promotion: The Move Towards a New Public Health, November 17-21, 1986 Ottawa, Ontario, Canada, 1986. Accessed July 12, 2002 at http://www.who.int/hpr/archive/docs/ottawa.html.

Necessary conditions for health (WHO)

- **Shelter**
- **Education**
- **Food**
- **Income**
- **Stable eco-system**
- **Sustainable resources**
- **Mobility**
- **Health Care**
- **Social justice and equity**
- **Trauma Reduction**

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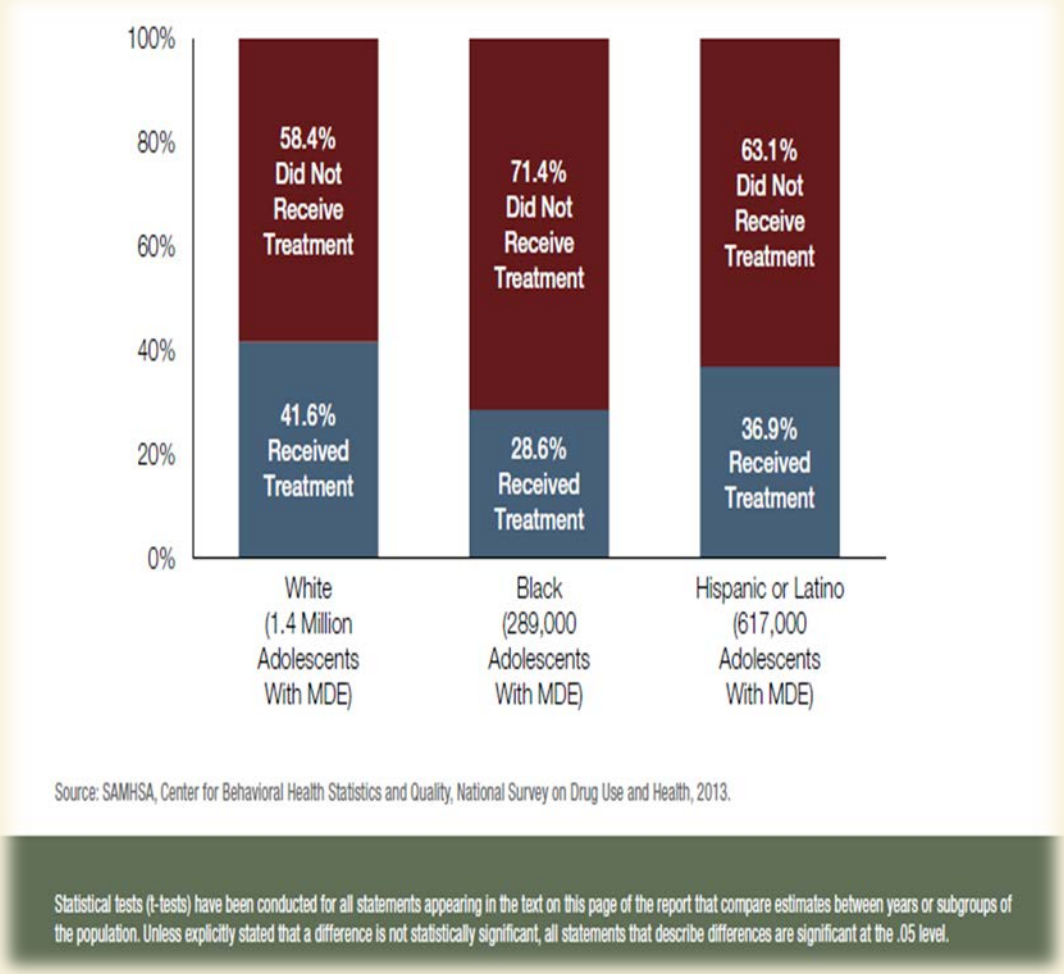
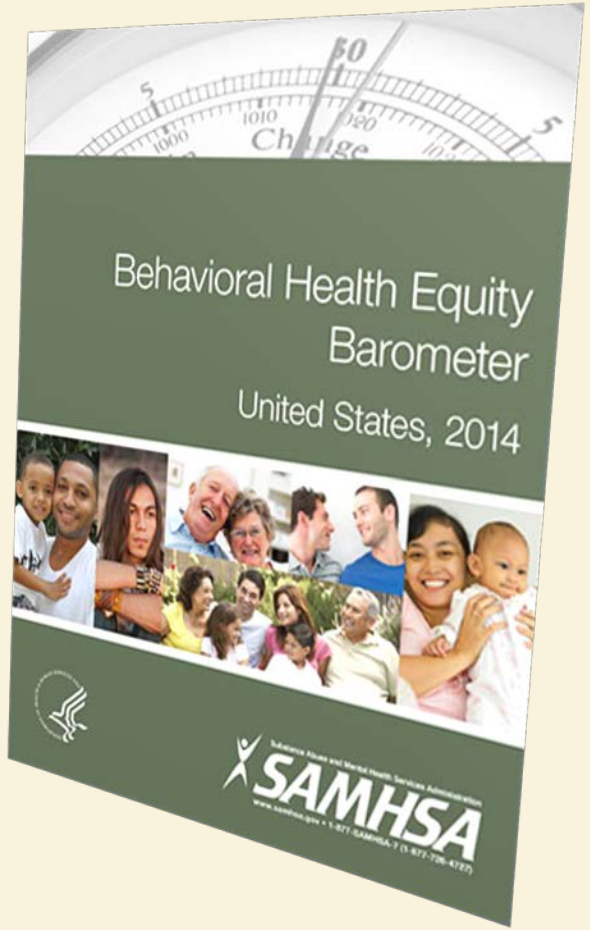
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

Past-Year Depression Treatment Among Adolescents Aged 12–17 With Major Depressive Episode (2013)



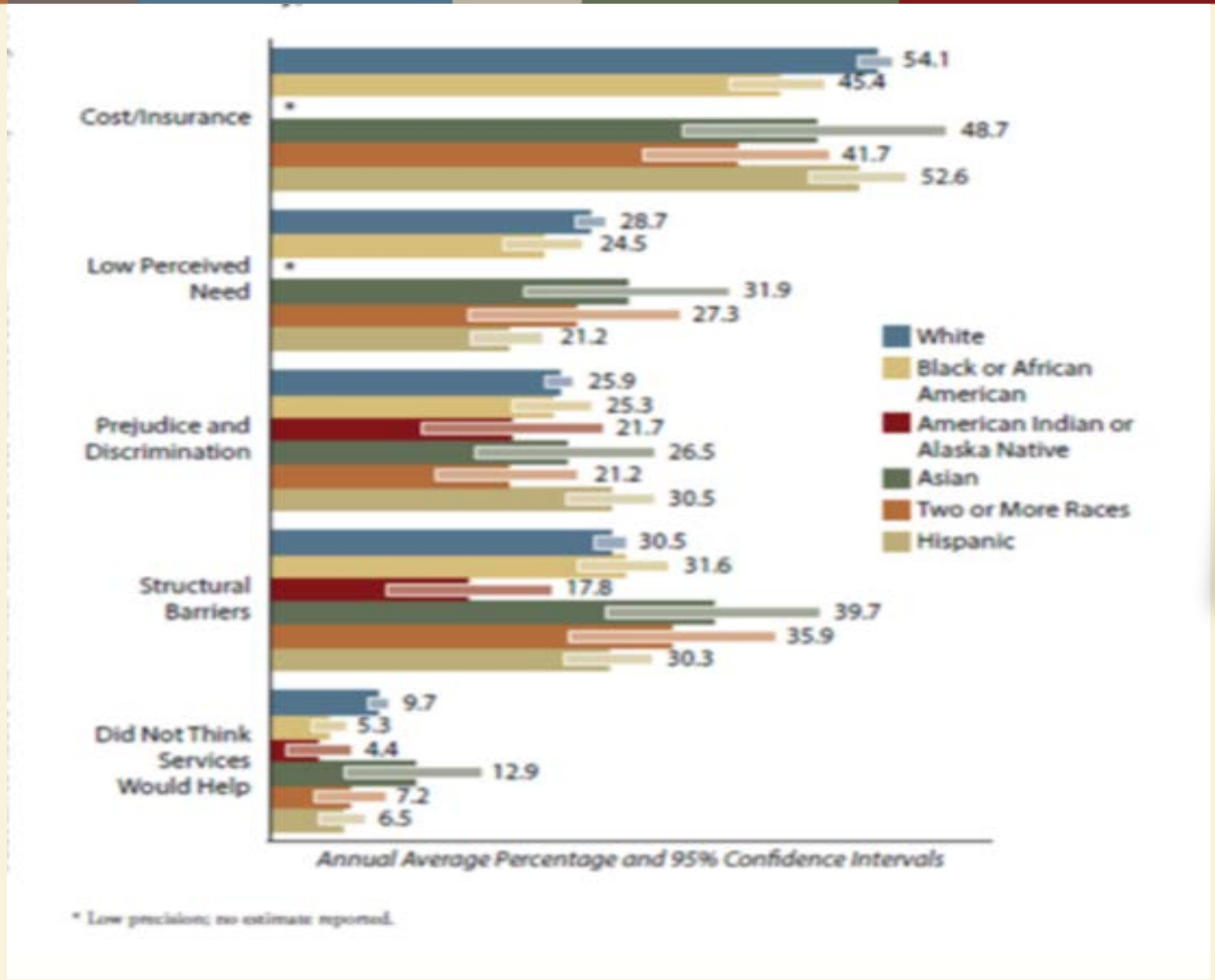
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013.

Statistical tests (t-tests) have been conducted for all statements appearing in the text on this page of the report that compare estimates between years or subgroups of the population. Unless explicitly stated that a difference is not statistically significant, all statements that describe differences are significant at the .05 level.



Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

Reasons for Not Using Mental Health Services 2008-2012



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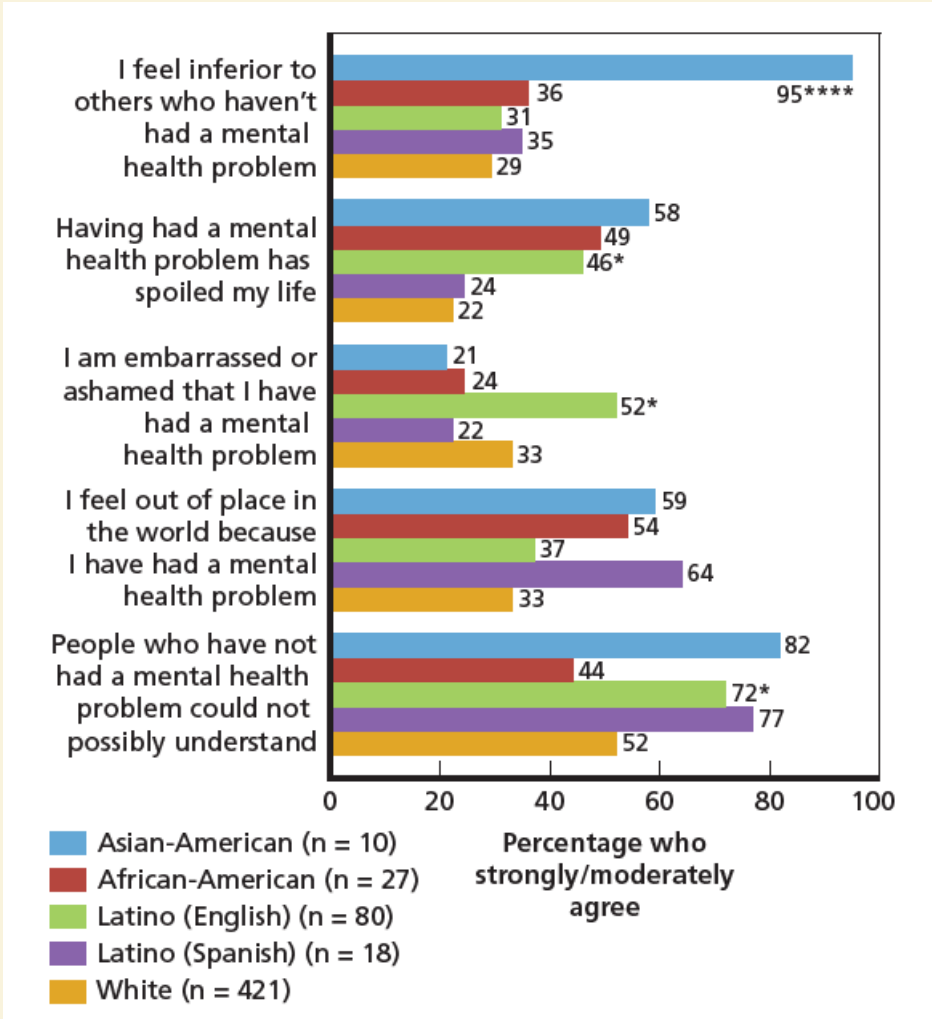
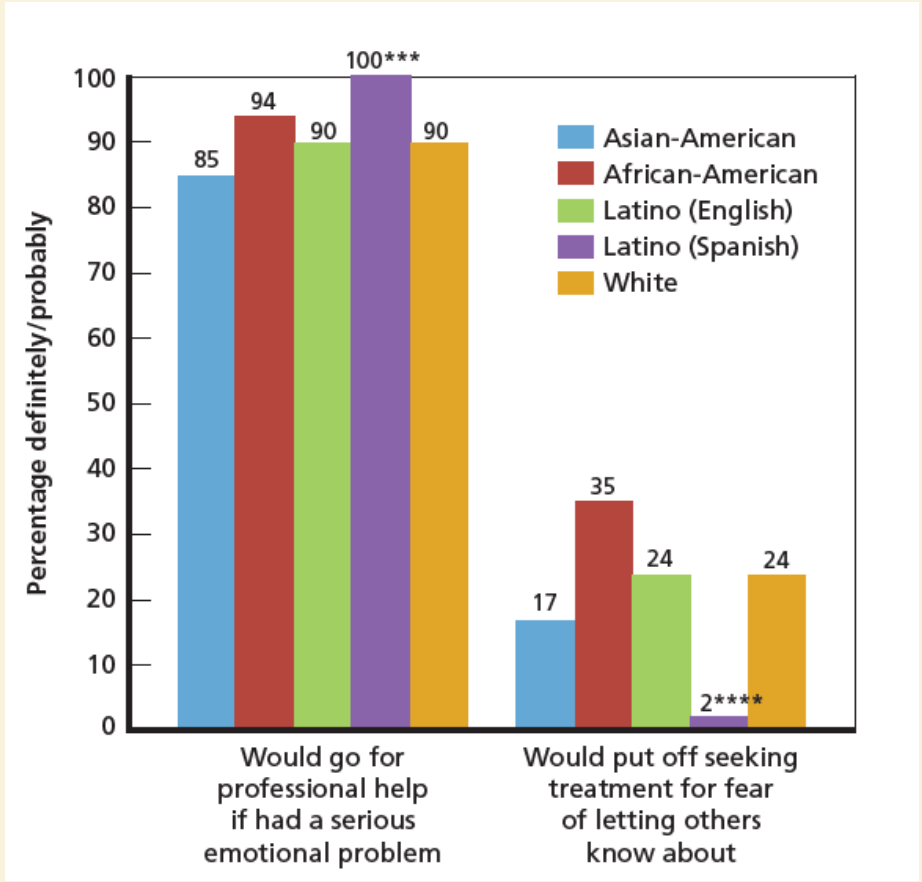
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

Stigma as a Barrier to Treatment

Self-stigma



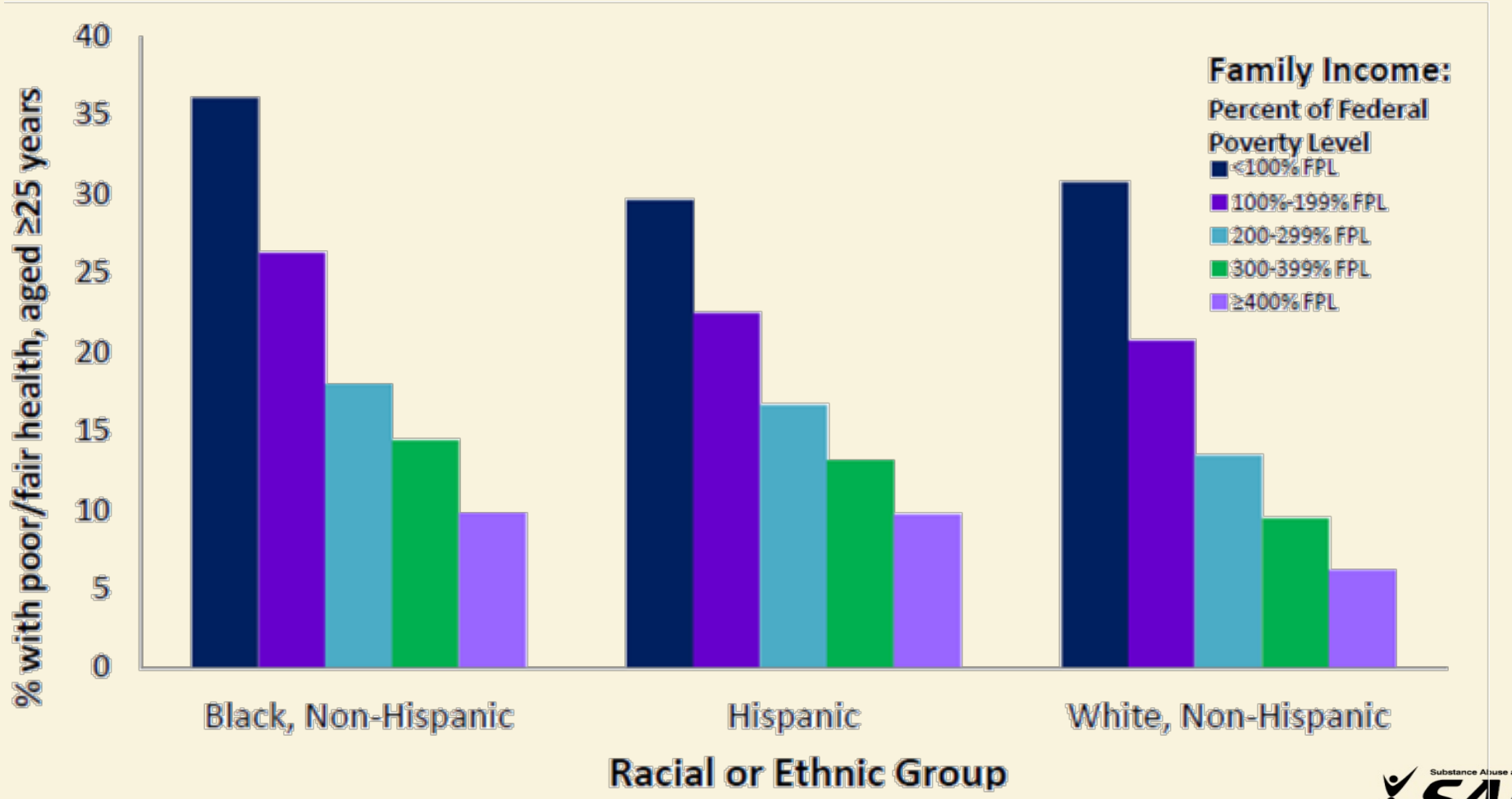
Treatment Attitudes



(Wong, Collins, Cerully, Seelam, & Roth, 2016)

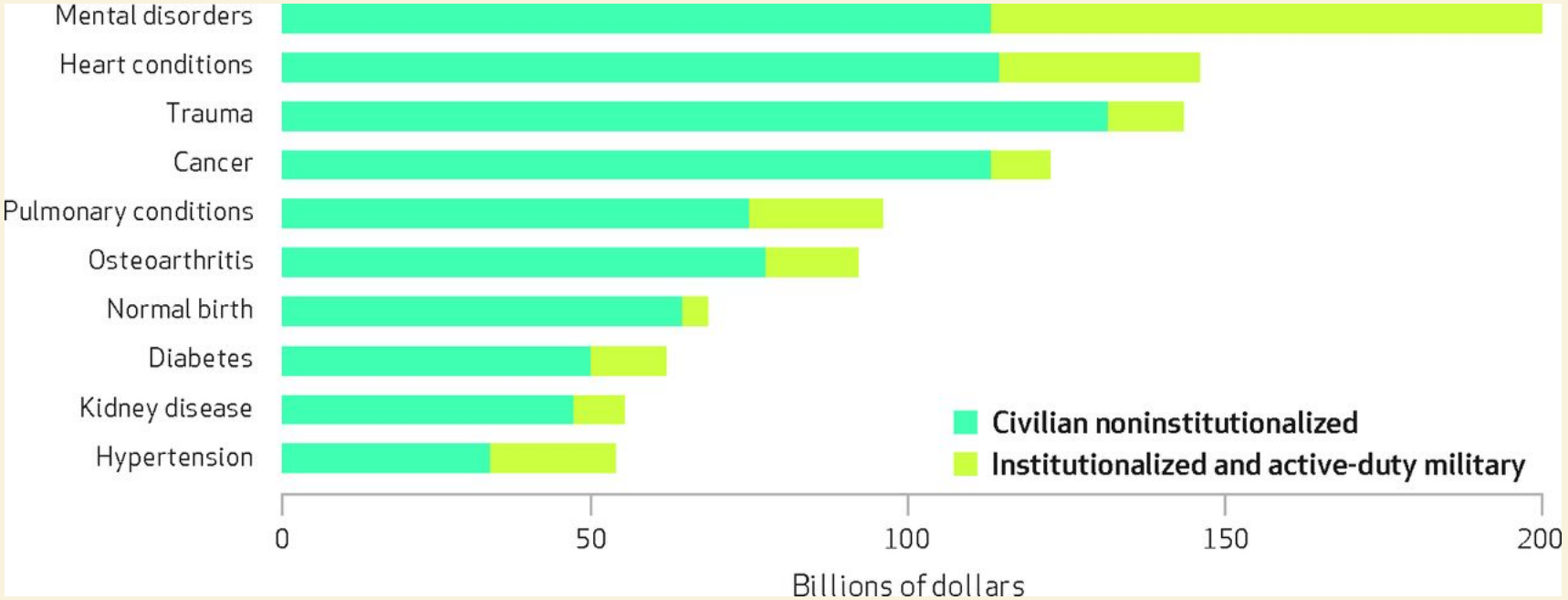
Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

Disparities: Poverty Level



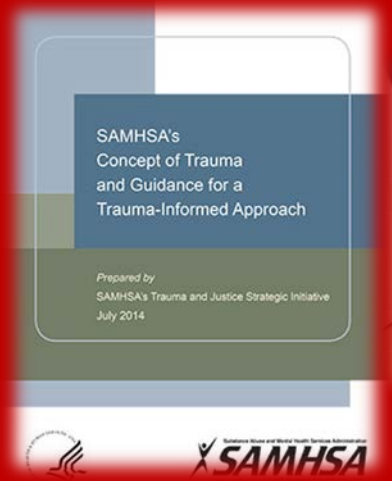
Source: Braverman, P. MD, (August 2012) Why should nurses be concerned with the social determinants of health and health disparities [PowerPoint presentation] retrieved from http://bhpr.hrsa.gov/nursing/2_braveman.pdf data source: NHIS 2001-2005 age adjusted

Ten medical conditions with the highest estimated spending in 2013



Charles Roehrig Health Aff 2016;35:1130-1135

©2016 by Project HOPE - The People-to-People Health Foundation, Inc.

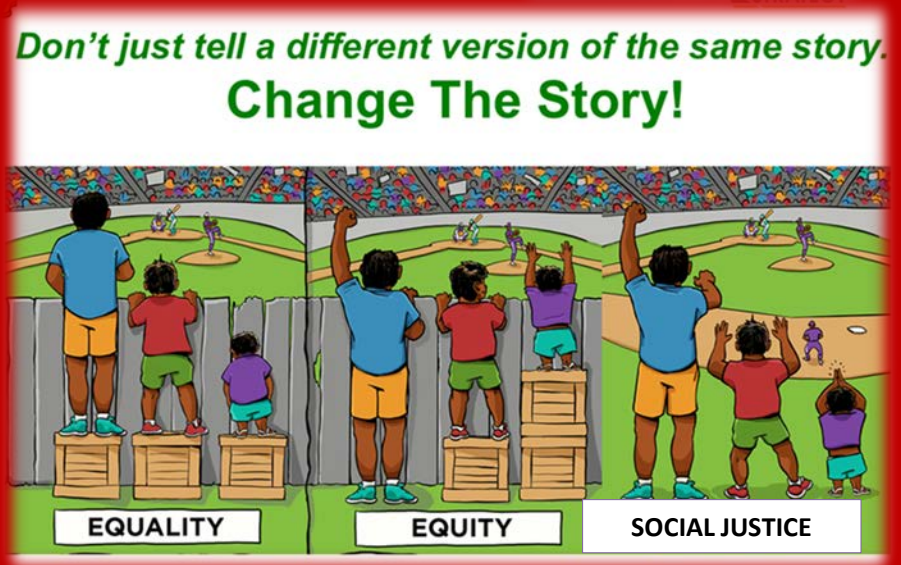

SAMHSA's
Concept of Trauma
and Guidance for a
Trauma-Informed Approach
Prepared by
SAMHSA's Trauma and Justice Strategic Initiative
July 2014
SAMHSA

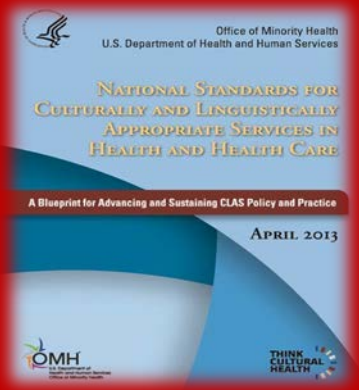

Outpatient Services
Treatment
Mental Health
Adults
Prevalence
Inpatient
Ethnicity

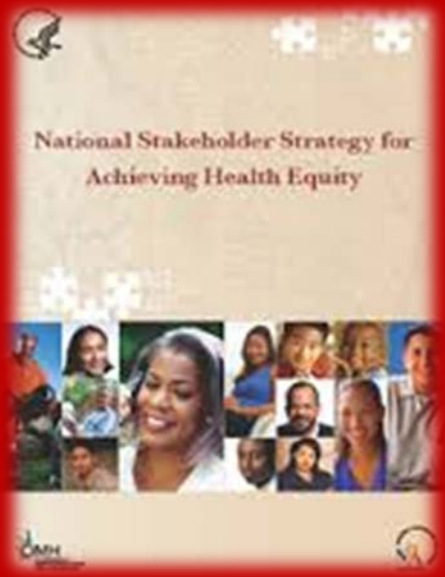

HHS Action Plan to Reduce Racial and Ethnic Health Disparities
A NATION FREE OF DISPARITIES IN HEALTH AND HEALTH CARE

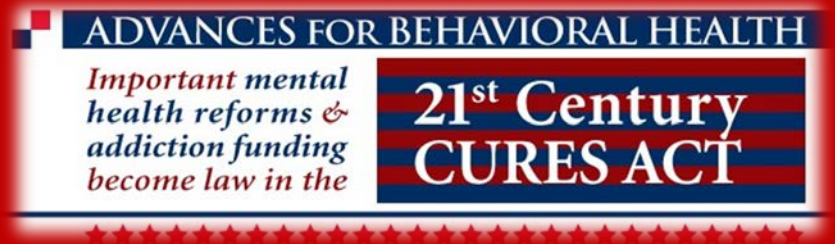

A TREATMENT IMPROVEMENT PROTOCOL
Trauma-Informed Care in Behavioral Health Services
TIP 57
SAMHSA

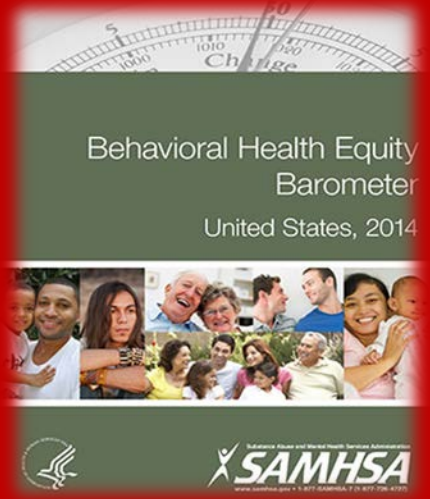

Healthy People 2020


Don't just tell a different version of the same story.
Change The Story!
EQUALITY
EQUITY
SOCIAL JUSTICE


Office of Minority Health
U.S. Department of Health and Human Services
National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care
A Blueprint for Advancing and Sustaining CLAS Policy and Practice
April 2013
OMH
THINK CULTURAL HEALTH

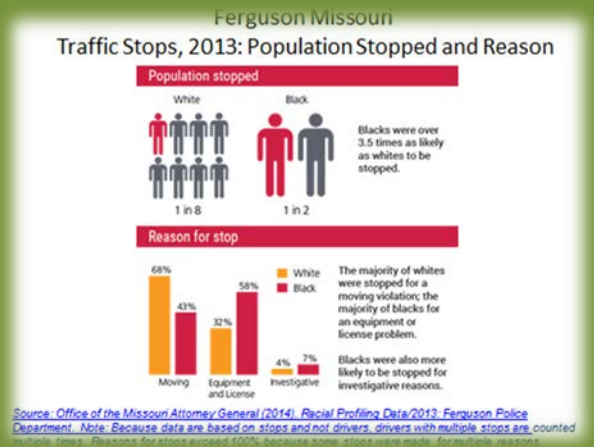

National Stakeholder Strategy for Achieving Health Equity


ADVANCES FOR BEHAVIORAL HEALTH
Important mental health reforms & addiction funding become law in the
21st Century CURES ACT


Behavioral Health Equity Barometer
United States, 2014
SAMHSA

Why do we continue to see such disparate behavioral health outcomes across our communities?


SELECTED SUBURBS OF ST. LOUIS
Black Jack
Ferguson
Berkeley
Kinloch
St. Ann
De Porres
(now part of
Breckenridge Hills)
Creve Coeur
ST. LOUIS
ST. LOUIS COUNTY
Kirkwood
Fenton


Ferguson Missouri
Traffic Stops, 2013: Population Stopped and Reason
Population stopped
White
Black
1 in 8
1 in 2
Blacks were over 3.5 times as likely as whites to be stopped.
Reason for stop
68%
43%
32%
58%
4%
7%
Moving
Equipment and License
Investigative
White
Black
The majority of whites were stopped for a moving violation; the majority of blacks for an equipment or license problem.
Blacks were also more likely to be stopped for investigative reasons.
Source: Office of the Missouri Attorney General (2014). Racial Profiling Data/2013: Ferguson Police Department. Note: Because data are based on stops and not drivers, drivers with multiple stops are counted multiple times. Reasons for stops exceed 100% because some stops were made for multiple reasons.


WE WANT WHITE
TENANTS IN OUR
WHITE COMMUNITY

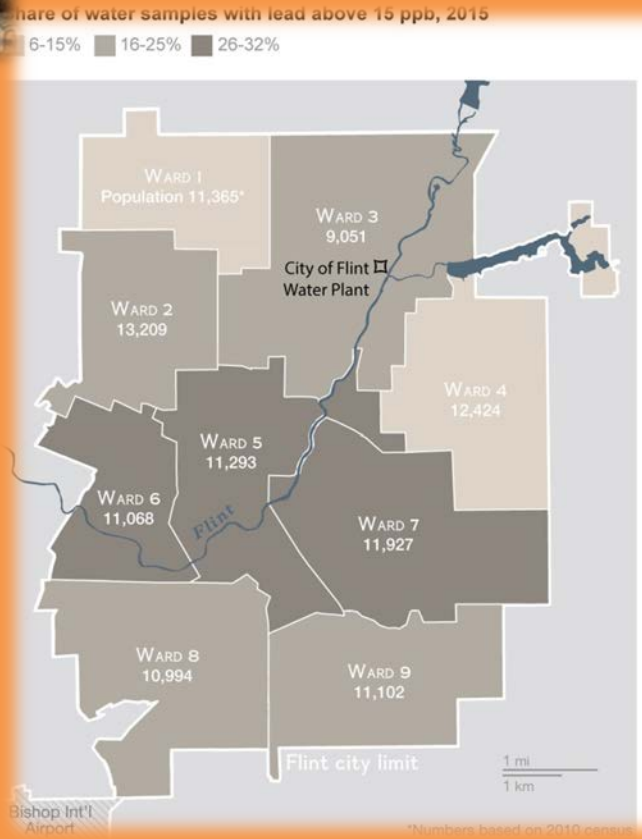

EXCUSE ME
WE NEED ANSWERS
FOR
Michael Brown Jr.
@ahkeon

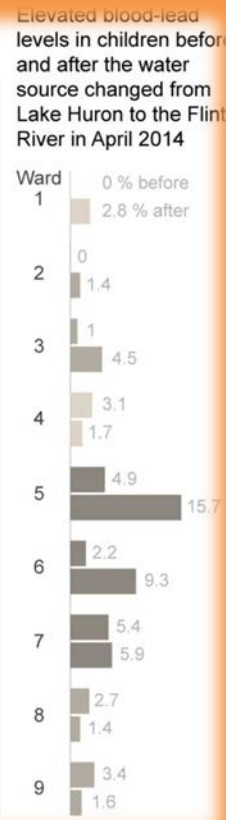

Community
TIME
Crisis


DON'T SHOOT.
I want to grow up.

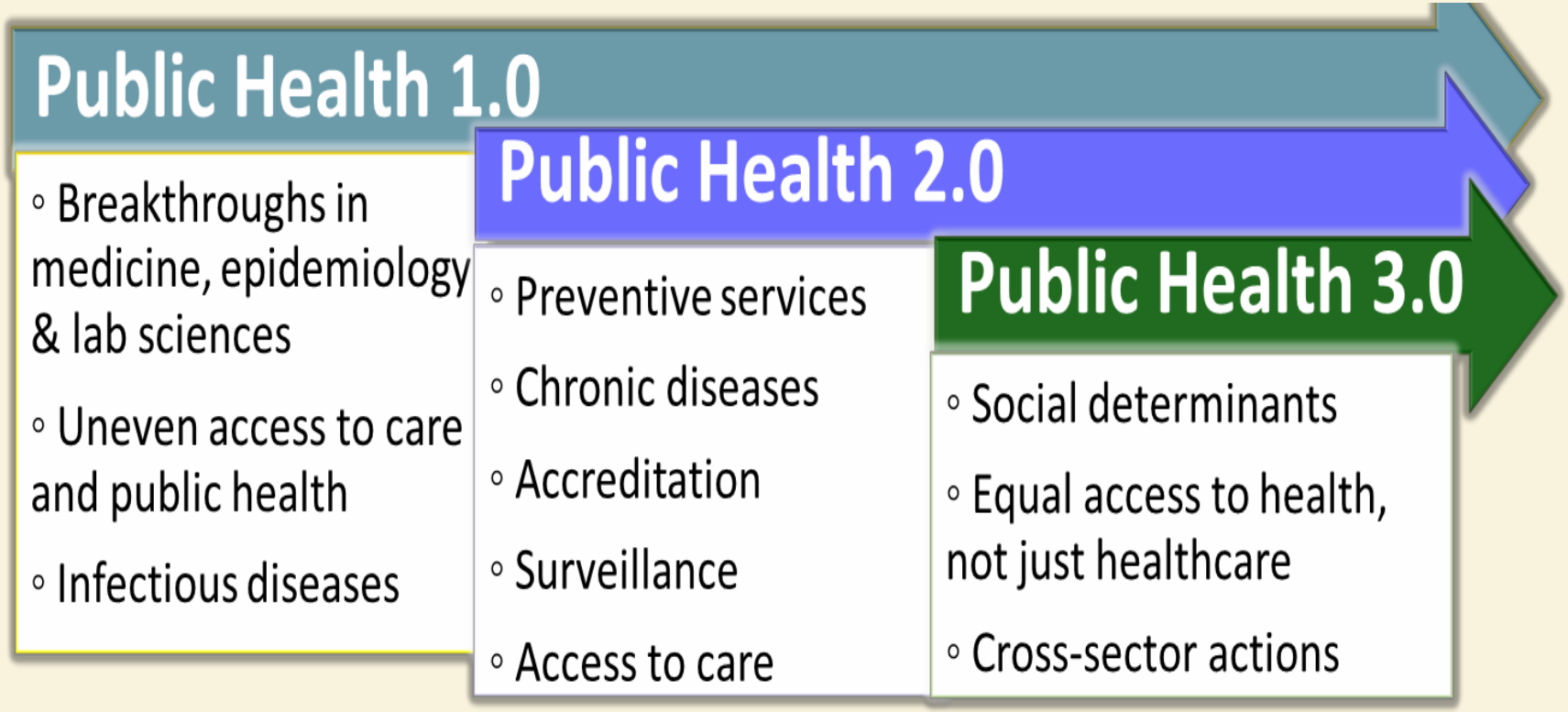

Saginaw Street, looking South,
Flint, Mich.
FLINT
VEHICLE CITY
CardCow.com


FLINT
LIVES
MATTER
FLINT
LIVES
MATTER


hare of water samples with lead above 15 ppb, 2015
6-15%
16-25%
26-32%
Ward 1
Population 11,365*
Ward 3
9,051
City of Flint
Water Plant
Ward 2
13,209
Ward 4
12,424
Ward 5
11,293
Ward 6
11,068
Flint
Ward 7
11,927
Ward 8
10,994
Ward 9
11,102
Flint city limit
1 mi
1 km
Bishop Int'l
Airport
*Numbers based on 2010 census


Elevated blood-lead levels in children before and after the water source changed from Lake Huron to the Flint River in April 2014
Ward
0 % before
2.8 % after
1
0
1.4
2
1
4.5
3
3.1
1.7
4
4.9
15.7
5
2.2
9.3
6
5.4
5.9
7
2.7
1.4
8
3.4
1.6
9

Emerging Framework for Service Delivery and Payment Models



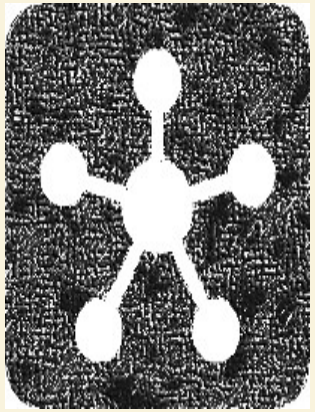
Karen DeSalvo, MD, MPH; Assistant Secretary for Health, DHHS

Public Health 3.0 Components

"emphasizes **cross- sector** environmental, policy- and systems- level actions that directly affect the SDOH."

LEADERSHIP & WORKFORCE

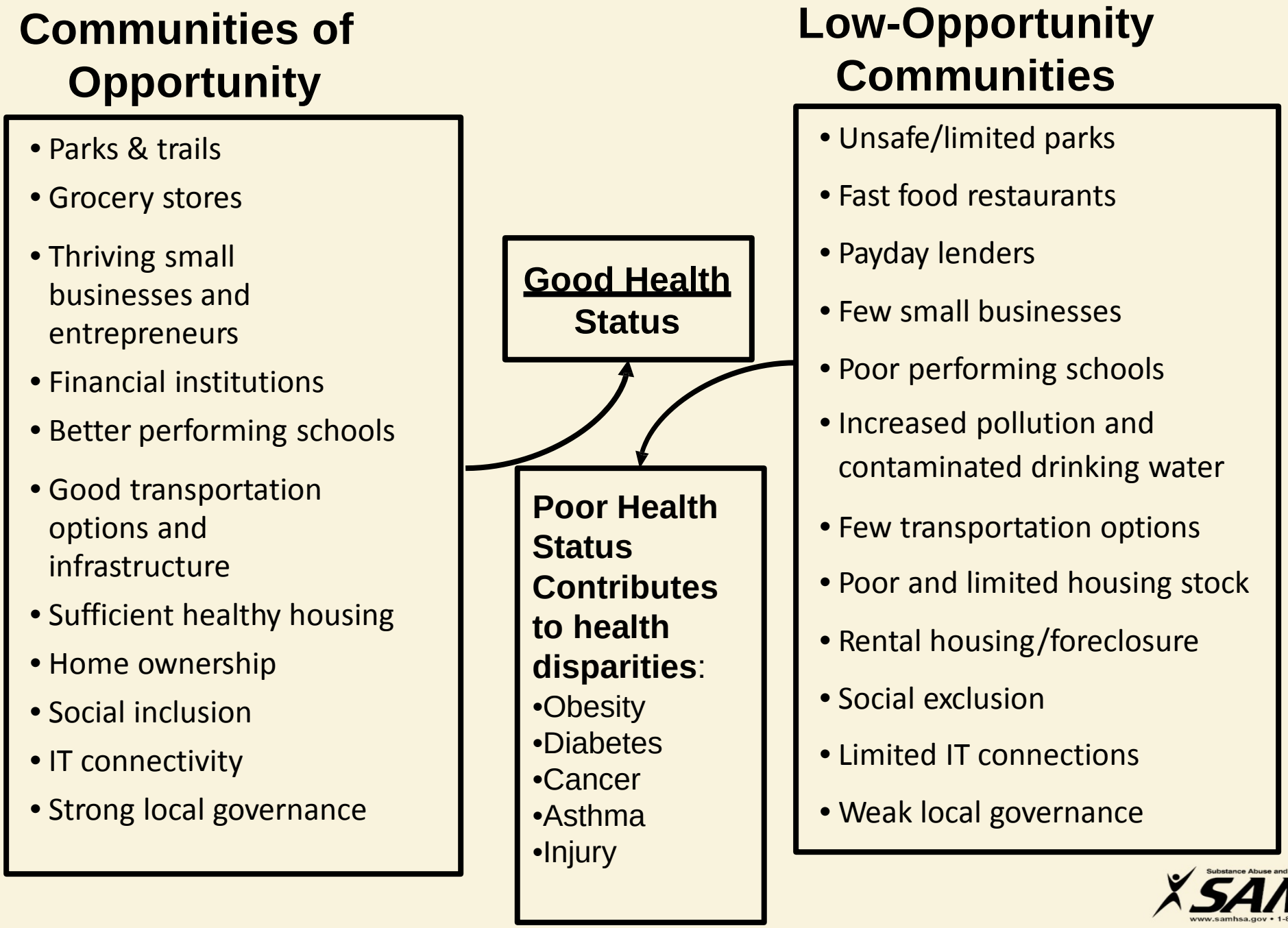
DATA, ANALYTICS & METRICS



ESSENTIAL INFRASTRUCTURE

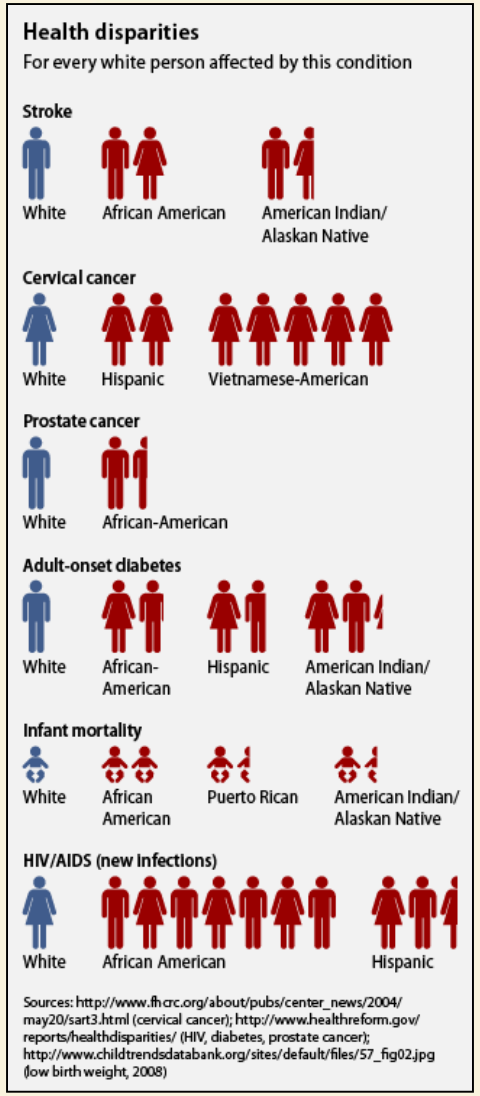
FLEXIBLE & SUSTAINABLE FUNDING

STRATEGIC PARTNERSHIPS



Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

Healthy People 2020 - Definition



Health disparity as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage.

Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."

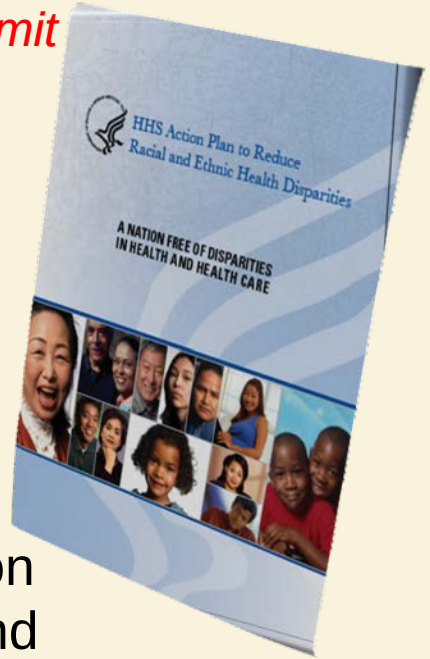
Disparity Impact Strategy Overview

HHS Action Plan to Reduce Racial and Ethnic Disparities

(Department of Health and Human Services, 2011)

Priority #1: "Assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that:

*(c)Program grantees, as applicable, will be required to submit **health disparity impact statements** as part of their grant applications*

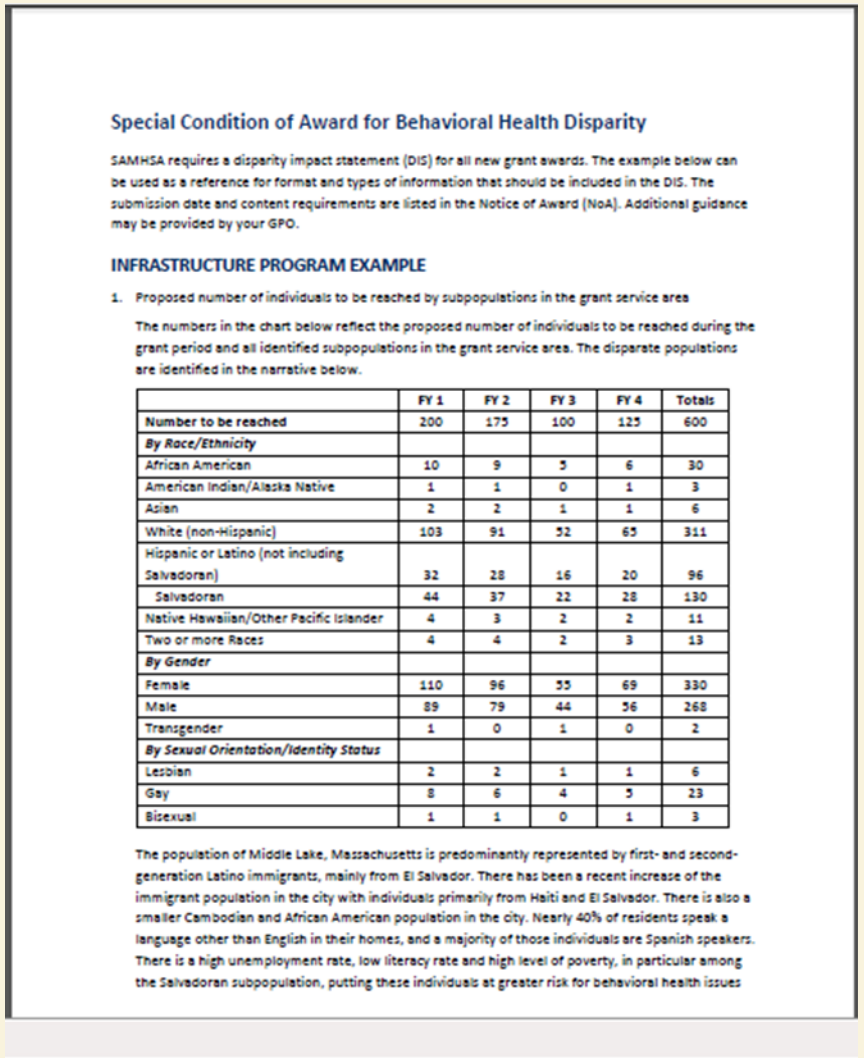


Program performance data, disaggregated by race and ethnicity used to determine differences in:

- **Access**
- **Use**
- **Outcomes**

Quality improvement used to align program implementation with the **National CLAS Standards** to reduce disparities and promote health equity.

What's Different?



Special Condition of Award for Behavioral Health Disparity

SAMHSA requires a disparity impact statement (DIS) for all new grant awards. The example below can be used as a reference for format and types of information that should be included in the DIS. The submission date and content requirements are listed in the Notice of Award (NoA). Additional guidance may be provided by your GPO.

INFRASTRUCTURE PROGRAM EXAMPLE

1. Proposed number of individuals to be reached by subpopulations in the grant service area

   The numbers in the chart below reflect the proposed number of individuals to be reached during the grant period and all identified subpopulations in the grant service area. The disparate populations are identified in the narrative below.

	FY 1	FY 2	FY 3	FY 4	Totals
Number to be reached	200	175	100	125	600
By Race/Ethnicity					
African American	10	9	5	6	30
American Indian/Alaska Native	1	1	0	1	3
Asian	2	2	1	1	6
White (non-Hispanic)	103	91	52	65	311
Hispanic or Latino (not including Salvadoran)	32	28	16	20	96
Salvadoran	44	37	22	28	130
Native Hawaiian/Other Pacific Islander	4	3	2	2	11
Two or more Races	4	4	2	3	13
By Gender					
Female	110	96	55	69	330
Male	89	79	44	56	268
Transgender	1	0	1	0	2
By Sexual Orientation/Identity Status					
Lesbian	2	2	1	1	6
Gay	8	6	4	5	23
Bisexual	1	1	0	1	3

The population of Middle Lake, Massachusetts is predominantly represented by first- and second-generation Latino immigrants, mainly from El Salvador. There has been a recent increase of the immigrant population in the city with individuals primarily from Haiti and El Salvador. There is also a smaller Cambodian and African American population in the city. Nearly 40% of residents speak a language other than English in their homes, and a majority of those individuals are Spanish speakers. There is a high unemployment rate, low literacy rate and high level of poverty, in particular among the Salvadoran subpopulation, putting these individuals at greater risk for behavioral health issues

- Increased awareness of and attention to vulnerable populations.
- Increased access to federal resources and involvement in federally-funded programs for disparity populations.
- Improved attention to outreach, engagement, retention and intervention strategies.

The National CLAS Standards

A BLUEPRINT FOR ADVANCING AND SUSTAINING CLAS POLICY AND PRACTICE

The Blueprint

is the implementation guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care

There are **15** standards

with 3 key intentions:

1. **advance health equity**
2. **improve quality**
3. **help eliminate health care disparities**

The Blueprint outlines

6 key reasons why health and health care organizations should adopt and implement the National CLAS Standards

- **Quality of care**
- **Changing demographics**
- **Marketplace**
- **Health disparities**
- **Legal mandates**
- **Risk of liability**

discusses the results of the 2010-13 enhancement initiative

- expanded definition of culture
- a broad understanding of health
- an audience of health & health care organizations

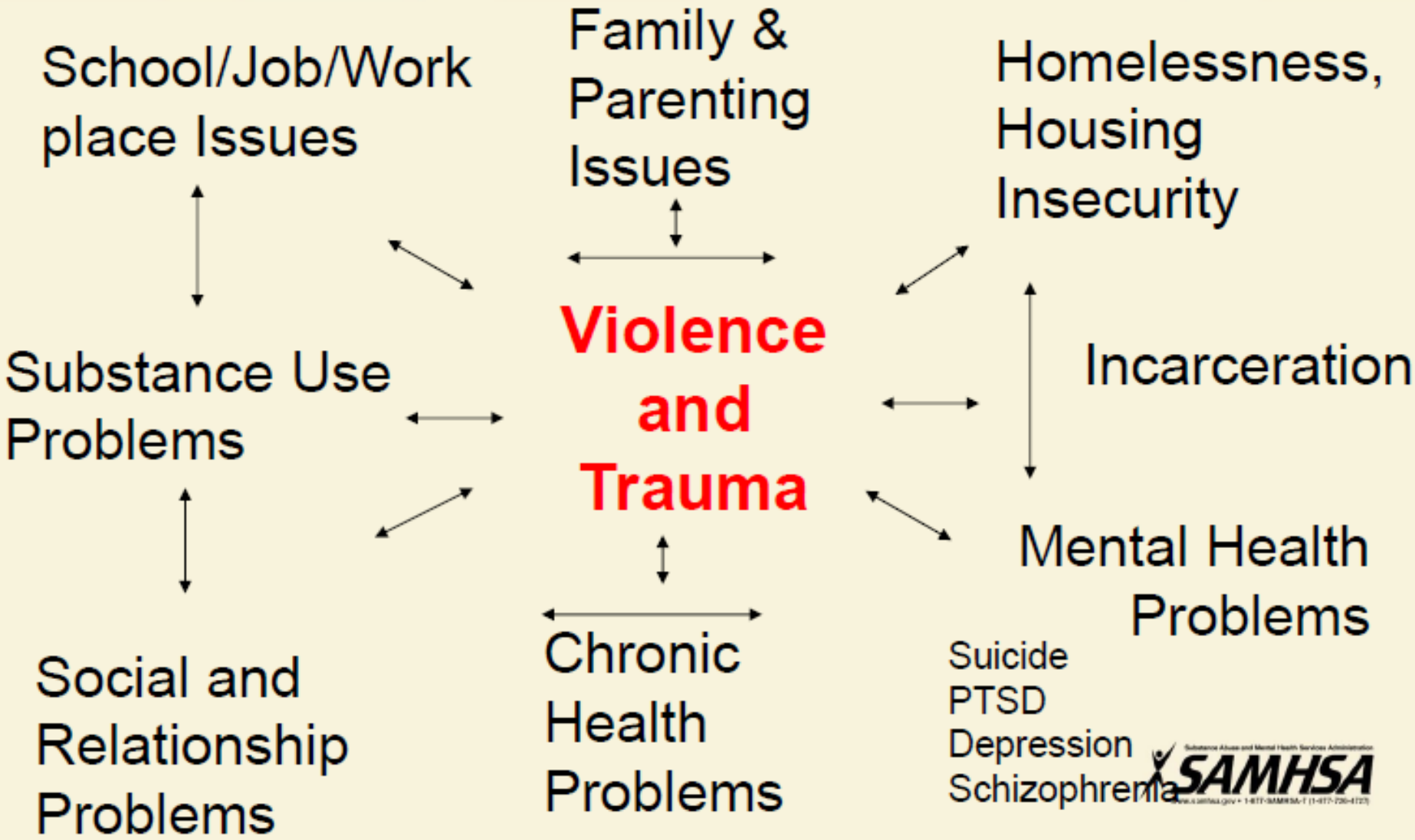
and explains each Standard

- **Purpose**
- **Strategies**
- **Meaning**
- **Resources**

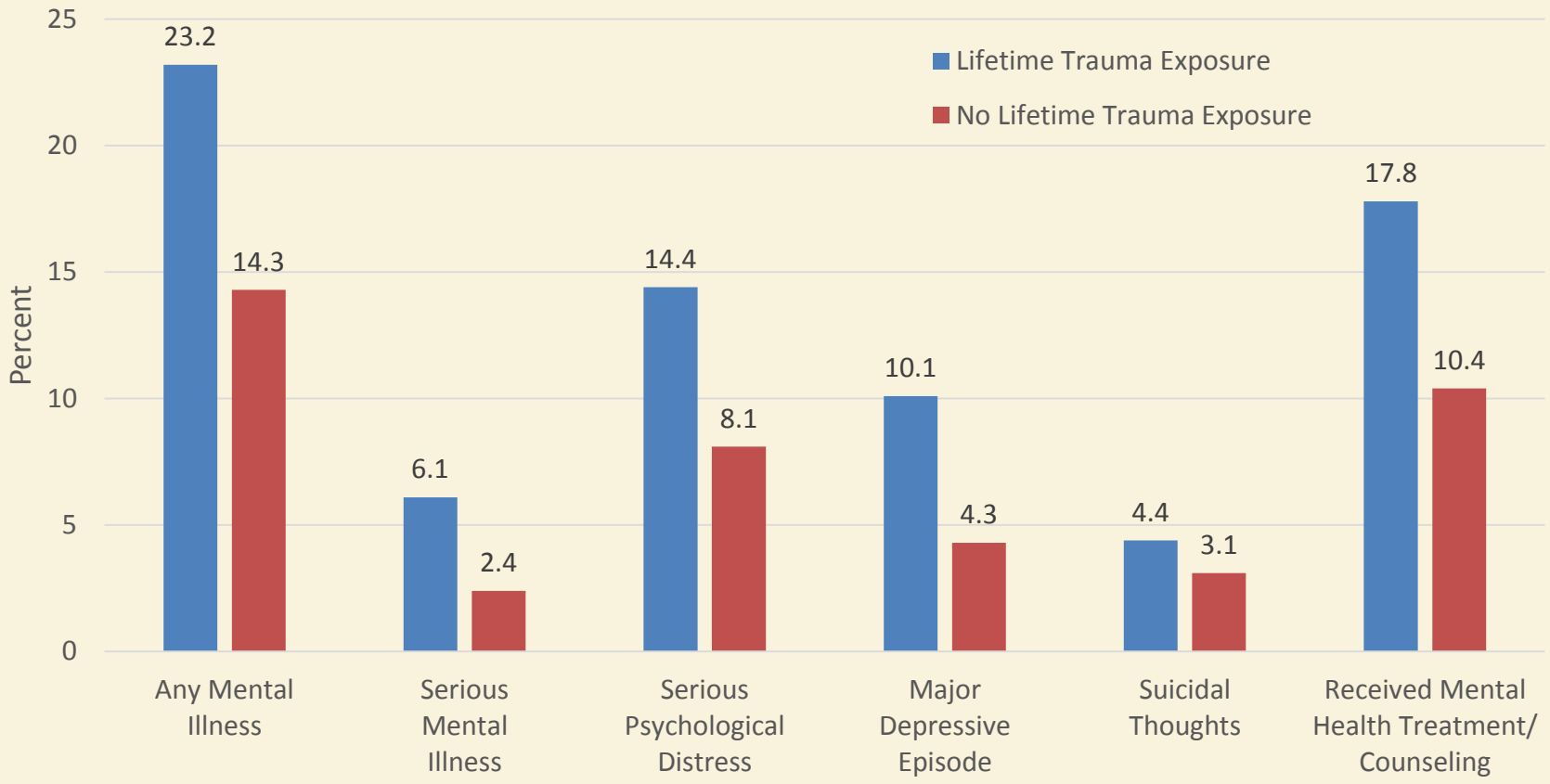
ReCAST Grant: Resiliency in Communities After Stress and Trauma

- For: Communities experiencing civil unrest
- Purpose:
  - Assist high-risk youth and families
  - Promote resilience and equity in communities
  - Use violence prevention/community youth engagement programs
  - Link with trauma-informed services
- Goal: local community entities and government (law enforcement, education, etc.) agencies to work together to improve behavioral health, empower community residents and reduce trauma
- http://www.samhsa.gov/grants/grant-announcements/sm-16-012

What is the Central Role of Trauma?



Mental Health Indicators among Adults Aged 18 or Older, by Lifetime Trauma Exposure: MHSS Clinical Study, 2008-2012 (*n* = 5,653)



CBHSQ Data Review, April 2016

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

Violence, Trauma and Health Care Engagement

Any experience of violence and trauma can affect an individual's engagement in health care:

- Repeatedly missed or cancelled appointments
- Avoiding preventive care
- Poor adherence to medical recommendations
- Chronic unexplained pain
- Anxiety about certain medical procedures

Understanding Disparities to Promote Behavioral Health Equity

- Assumes reciprocal inter-connectedness between the community's health and wellbeing and that of individual community members
- Social determinants of health as a foundation
- Partnerships to engage community & service systems
- Collective ownership & coordinated action

What if…

behavioral health equity was the starting point for decision-making and innovation?

Substance Abuse and Mental Health Services Administration
SAMHSA
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Thank you!

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SAMHSA Office of Behavioral Health Equity
http://www.samhsa.gov/behavioral-health-equity

Special Acknowledgement

Melodye Watson, SAMHSA - ReCAST Program Lead
Michael Awad, PhD Candidate, Teachers College, Columbia University